Virginia Department of Health - Office of Emergency Medical Services
109 Governor Street, Suite UB-55, Richmond, VA 23219

AUTHORIZATION FOR REINSTATEMENT OF STATE EMS CERTIFICATION
VOLUNTARILY INACTIVATED

REQUEST FOR REINSTATEMENT OF INACTIVE EMS CERTIFICATION

The person named below has applied to the Virginia Office of EMS for REINSTATEMENT of their Virginia EMS provider certification which was voluntarily placed in INACTIVE status at the following level:

____ First Responder ____ EMT-Basic ____ EMT-Shock-Trauma
____ EMT-Cardiac ____ EMT-Paramedic ____ EMT-Instructor

REFERENCE: _____DATE OF REQUEST:_____/_____/_____

_____

_____

SS# _____-_____-_____ STATE CERTIFICATION # _____ (If different)

PROVIDER ACKNOWLEDGMENT:

The provider's EMS certification at the indicated level has been recorded as INACTIVE in the Virginia Office of EMS records system at their request. Since being placed into INACTIVE status, the provider has not been authorized to practice at the indicated INACTIVE level in any capacity which requires this certification level under the Virginia Rules & Regulations Governing Emergency Medical Services. Upon receipt of this authorization, the EMS certification indicated above will be reviewed for reinstatement to ACTIVE status.

If the INACTIVE level is an advanced life support or instructor level, the individual has reverted to EMT-Basic certification status as their highest authorized level of practice. Such EMT-Basic certification has remained valid for the remainder of the INACTIVE certification period plus two additional years.

Once placed in INACTIVE status, such certification must have been maintained for a **minimum period of six(6) months** from the effective date issued by the Office of EMS before this request for reinstatement will be accepted.

Applicant Signature: _____

AFFILIATION INFORMATION:(To be completed by each EMS agency's Operational Medical Director - Submit a separate form for each supervising OMD)

EMS Agency(ies) of Affiliation:

_____

_____

_____

1) Is this person currently practicing in a state licensed EMS agency for which you serve as the Operational Medical Director? YES ____ NO ____

If YES, what certification level is currently practiced:(check one) ____ First Responder ____ EMT-Basic
____ EMT-Shock-Trauma ____ EMT-Cardiac ____ EMT-Paramedic ____ EMT-Instructor

2) Were you aware that this person's state certification at the level listed above had been placed in INACTIVE status at their request? YES ____ NO ____

If YES, is reinstatement of the above certification a mandatory requirement for continued membership/employment with this EMS agency? YES ____ NO ____

If NO, is the above certification a mandatory requirement for continued service in; or advancement to; a specific capacity, position or job classification with this EMS agency? YES ____ NO ____

(Continued over)

LEGAL/DISCIPLINARY RESTRICTIONS:

3) Is this person's membership/employment currently under investigation, suspension or revocation by this EMS agency: YES ____ NO ____

If YES, explain:

_____

_____

_____

_____

4) To your agency's knowledge, has this person EVER been convicted of a FELONY: YES ____ NO ____

If YES, did this FELONY involve a crime of a sexual nature: YES ____ NO ____

5) To your agency's knowledge, is there any reason why this person's certification should not be returned to ACTIVE status by the Virginia Office of EMS?: YES ____ NO ____

Approval for reinstatement of this provider's EMS certification to ACTIVE status by the Virginia Office of EMS does not obligate any EMS agency to authorize this person to practice at the reinstated level. Field practice authority rests solely with each EMS agency and its licensed Operational Medical Director.

Approving Operational Medical Director:_____
Printed Name Signature State OMD#

Phone number to contact above OMD: (_____) _____

Thank you for providing this information - Mail this form directly to the address above -
Do not return to provider for mailing.

OFFICE OF EMS USE ONLY

Date received: _____/_____/_____ Date Reviewed: _____/_____/_____

Reviewed by: _____

Approved:_____ Denied: _____ Reason for Denial:_____

If Approved, effective date of reinstatement: _____/_____/_____ (Entered into records system)

Entered into system by: _____

IF MULTIPLE OMD FORMS RECEIVED - FILE ALL FORMS TOGETHER